HEALTH COMMITTEE

Tuesday 3 October 2006

Session 2

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HEALTH COMMITTEE
21st Meeting 2006, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Seán Boyle (Adviser)
David Christie (Samaritans)
Jane Davidson (Scottish Executive Health Department)
Paul Gray (Scottish Executive Health Department)
Anne Hawkins (NHS Greater Glasgow and Clyde)
Geoff Huggins (Scottish Executive Health Department)
Derek Lindsay (NHS Ayrshire and Arran)
Dr Donny Lyons (Mental Welfare Commission for Scotland)
Lewis Macdonald (Deputy Minister for Health and Community Care)
Allyson McCollam (Scottish Development Centre for Mental Health)
Kay McCorquodale (Scottish Executive Legal and Parliamentary Services)
Christina Naismith (Association of Directors of Social Work)
Shona Neil (Scottish Association for Mental Health)
Peter Williamson (NHS Tayside)

CLERK TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 3 October 2006

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Roseanna Cunningham): Good afternoon. I ask the committee to agree to take item 6 in private. It concerns a discussion of the evidence that we will by then have heard on the mental health budget. Do we agree so to do?

Members *indicated agreement.*

Mental Health Budget 2007-08

The Convener: Item 2 on the agenda is a round-table discussion on the mental health budget. We have many documents that provide background for the discussion. Before we begin, I will remind everyone of the basis on which we run these round-table sessions. This year, we are focusing on the Scottish Executive's mental health budget. As well as considering the figures for 2007-08, we are examining the trends in order to see the wider picture. We have, therefore, commissioned Dr Seán Boyle of the London School of Economics, who is with us today, to undertake research into spending on mental health by all area health boards. He has also conducted more detailed interviews with NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde and NHS Tayside, all of which are represented here today.

Also represented around the table are bodies that deal with people with mental illness, officials from the Scottish Executive and people from the Mental Welfare Commission.

Following the round-table discussion, the Deputy Minister for Health and Community Care, Lewis Macdonald, will give evidence on the mental health budget. People are free to stay if they want to listen to the minister.

The evidence will focus on four specific areas of the mental health budget. The discussion on each area will be led by a different member of the committee. The four areas are: the allocation of expenditure to mental health, which will be led by Shona Robison; local authority and voluntary sector contributions to mental health expenditure, which will be led by my deputy convener, Janis Hughes; the shifting pattern of expenditure from acute to community-based care, which will be led by Euan Robson; and the implications of the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, which will be led by me. When I say "led by", I mean that those committee members will simply introduce the topic. Round-table discussions are not sessions in which I expect the members to dominate. I always hope to encourage as much intervention and discussion as possible from those who are around the table, including cross questioning each other, if they feel that that is appropriate.

The health boards have been invited to represent case studies of the changes in mental health expenditure rather than to answer questions about every detail of their expenditure. I ask members who might have axes to grind with regard to certain health boards not to try to use this discussion as an opportunity to pinpoint specific issues.

I should also say that Dr Seán Boyle's draft report includes a number of provisional figures, some of which have subsequently been revised by some health boards.

I now ask everyone to introduce themselves. I am the convener of the Health Committee.

Janis Hughes (Glasgow Rutherglen) (Lab): I am the deputy convener.

Dr Donny Lyons (Mental Welfare Commission for Scotland): I am the director of the Mental Welfare Commission.

Kate Maclean (Dundee West) (Lab): I am a member of the committee.

Derek Lindsay (NHS Ayrshire and Arran): I am the director of finance with NHS Ayrshire and Arran.

Euan Robson (Roxburgh and Berwickshire) (LD): I am a member of the committee.

Christina Naismith (Association of Directors of Social Work): I represent the Association of Directors of Social Work, whose mental health group I chair.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I am a member of the committee.

Shona Neil (Scottish Association for Mental Health): I am the chief executive of the Scottish Association for Mental Health.

Geoff Huggins (Scottish Executive Health Department): I am the head of the Scottish Executive's mental health division.

Anne Hawkins (NHS Greater Glasgow and Clyde): I am director of the mental health partnership in NHS Greater Glasgow and Clyde.

Allyson McCollam (Scottish Development Centre for Mental Health): I am the chief executive of the Scottish Development Centre for Mental Health.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am a member of the committee.

Peter Williamson (NHS Tayside): I am the director of health strategy with NHS Tayside.

Helen Eadie (Dunfermline East) (Lab): I am a member of the committee.

David Christie (Samaritans): I represent Samaritans.

Shona Robison (Dundee East) (SNP): I am a member of the committee.

The Convener: The next two gentlemen are official reporters. They are taking down every word that you say, so you have that hanging over your head.

Dr Seán Boyle (Adviser): I am the budget adviser to the committee.

The Convener: For the purposes of this discussion, Seán Boyle is also a witness, so he can be included in the questioning. Feel free to ask him about anything that has arisen in the context of his paper.

I ask Shona Robison to introduce the first general area of the discussion. I expect this part to take about 15 minutes.

Shona Robison: The first area of discussion today concerns the allocation of expenditure to mental health. I want to draw people's attention to one or two things in the background paper from the adviser. All three boards with which our adviser conducted detailed interviews seemed to base their mental health expenditure on past levels of spend, rather than on a formula. However, none of the boards seemed to have a clear idea of what their spend on mental health was as a proportion of the total spend, how that compared with other boards or the national formula and whether it bore any relation to local needs for mental health services. There were also issues about ring fencing, which none of the boards thought was a good idea, and there was some criticism of the Arbuthnott formula, as it relates to mental health. Finally, there was some criticism of the Scottish Executive's role in assisting in the implementation of mental health policies.

What are people's thoughts about how decisions should be made about how much money is required for mental health?

Peter Williamson: How much money we allocate to mental health services is important. Our experience, which I think is shared by other boards in Scotland, is that boards use the historical budget as a starting point, but are continually looking at needs, which are expressed through a variety of sources, such as population information, information from service users and carers, good practice guidance from the Executive and so on. It is important to stress that, across all health boards, the position is not a matter of simply rolling out a budget. In fact, in Tayside, there will be extensive investment over the next five years in virtually all areas of mental health care. That is being driven by an assessment of needs for particular groups, such as older people with mental health problems, adults in general, people with eating disorders and so on. Needs assessment is important, but boards would not subscribe to doing a global assessment of all mental health needs. That would be difficult to undertake.

It is fair to say that the approach that is taken by the Executive and possibly by health boards has tended to give mental health issues less prominence than acute medicine and surgery. I honestly cannot say what that adds up to, but I think that there is a need to review our approach to how we assess needs and allocate funds to people with mental health problems.

Anne Hawkins: Since 1993, Greater Glasgow and Clyde NHS Board has tried to have a clear strategic plan for mental health services. The issue is not simply to do with looking back on historical spending levels; it is about trying to plan for the future. Realistically, such plans are usually based on five-year chunks. We are in the last stages of Glasgow's current five-year strategy on modernising mental health, and we are about to work up a new strategy that will take us through the next five years.

Boards try to take the strategies for all the various care groups and unite them into an overall health care strategy. It is incredibly challenging to balance all those elements. Since the mid-1990s, there has been a significant change in the balance between care in hospitals and care in the community. I know that we will talk about that later, but it is primarily the pot of money associated with hospital care—the large institutions—that has been used to reinvest in mental health care, with some additions, depending on the board. In Glasgow, the board has certainly added to that pot in recent years.

Derek Lindsay: It was said that none of the boards has a clear idea of a number of things, including the spend on mental health as a proportion of total spend. In our annual accounts, we provide detail on all the various care groups and so forth, so there is clarity on what is spent on mental health at least annually and, in terms of monitoring, on an in-year basis.

On the point about comparing that spend with that of other boards, the information in "Scottish Health Service Costs" allows us to make such comparisons. It became obvious from the exercise that Seán Boyle led that it is sometimes difficult to compare things between boards because there are different definitions—for example, the definition of out-patients might include only new out-patients or it might include return out-patients as well. However, in "Scottish Health Service Costs" there is an attempt to achieve consistency.

Seán Boyle's report also asks whether spend on mental health services bears any relation to the local need for mental health services. Each year, we carry out a prioritisation process that considers the main cost pressures. Although we have a five-year look ahead, as Anne Hawkins said, we have to allocate budgets based on identified needs. Within NHS Ayrshire and Arran there is a well-developed prioritisation process that includes the clinical groups and identifies the major cost pressures. For example, there have been significant developments in recent years due to the Mental Health (Care and Treatment) (Scotland) Act 2003.

Shona Neil: I would like to broaden the discussion to include the wider financial envelope. SAMH commissioned research from the Sainsbury Centre for Mental Health on the social and economic costs of mental health problems in Scotland. We will launch the report in November—the timing is not brilliant for the committee, unfortunately. The Sainsbury centre has already done similar research in England and Northern Ireland.

The report is not complete but the findings are unlikely to change and they suggest that the social and economic cost of mental health problems in Scotland is some £8.6 billion. Expenditure on health and social services probably accounts for just under 18 per cent of that. The other costs include output losses, including welfare benefits and the cost of lost work, but more than half of the cost is absorbed by people with mental health problems and their families. Given that there is such an impact on our society in Scotland, we need to ensure that every penny that we invest in the promotion of mental health and the treatment of mental health problems delivers outputs in terms of recovery for people.

The Convener: That is great, but do you have any practical suggestions on how that might be brought about?

Shona Neil: We tend to consider things in silos. Mental health problems affect the health service, which we are considering today, but they have a cross-cutting impact on every Executive portfolio. We must ensure that we consider the impact of the money that we spend in the health budget on people's economic outputs and social circumstances. We may make some practical suggestions in the report, but we must ensure that mental health is a cross-cutting priority that applies not only to health but, for example, to employment. We must look at the changes that are happening in employment, which may compound people's mental health problems. There is a lack of opportunity for people to get back into the workforce after having had a mental health problem and been out of work.

14:15

The Convener: I ask people to focus on budgets and how they are devised, and whether there are better ways of doing that. That is what we are trying to get at.

Kate Maclean: Anne Hawkins said that there are now more community-based mental health services, which are surely more expensive than hospital-based services. According to table 3 in the committee adviser's report, the total expenditure on mental health services has fallen in every health board, with the possible exception of Lothian. What is the explanation for that? Are local authorities picking up some of the expenditure by funding community-based services? Surely if health boards are spending less money on mental health it means poorer NHS services on the one hand and more reliance on more expensive community-based services on the other.

The Convener: I think that that question was directed at Anne Hawkins.

Anne Hawkins: Derek Lindsay and I were looking at each other to see who would answer it.

I do not think that table 3 in the report is 100 per cent accurate, and I am not sure how it relates to the "Scottish Health Service Costs" document that Derek Lindsay mentioned earlier. For example, the report does not provide any details of the overall increase in the health budget for each board and the actual mental health budget. I do not feel that it gives the full picture.

Shona Robison: But part of the problem with mental health spend is that one gets different figures depending on how things are calculated. We want to find out whether the money allocated by the Scottish Executive for mental health services is finding its way into those services. The report says:

> "The Scottish Executive has used minimal targeted funding, and has been ineffective in its attempts to monitor the degree to which such funds have been routed to mental health."

In that case, should the money destined for mental health be ring-fenced to ensure that it reaches those services?

Peter Williamson: No, because doing so would cause problems with the overall allocation of funds in a health board. As everyone knows, boards receive a general allocation based on the Arbuthnott formula and should have a certain amount of discretion in deciding, in light of local circumstances and needs, how best to use those funds.

I agree with your suggestion that there needs to be a clearer understanding of what a good mental health service looks like, what it should deliver, how it meets people's needs and how it should be funded. Progress has been made in that respect in acute medicine and surgery and, although it will be more difficult, the same approach should be taken with mental health services.

The Convener: I wonder whether the non-health board witnesses can respond to the question, because I imagine that the witnesses from the health boards will all agree about ring-fencing.

Dr Lyons: I completely agree with Peter Williamson. The mental health delivery plan must set out what a good mental health service looks like and how it should be measured. The committee will find—as the rest of us have found—that it is difficult to link expenditure to the delivery of mental health outcomes in any meaningful and systematic way. It is simply not that easy to do with mental health services—indeed, it is certainly not as easy as, for example, measuring cancer survival rates. Of course, that does not mean that we should duck the subject. We should all look to the mental health delivery plan to help us in this matter.

Shona Neil: For a number of years, we have argued that mental health resources need to be ring fenced, partly because they are so difficult to track. I accept some of the concerns that have been expressed, but ring fencing will be needed until we have a mechanism that allows us to see what happens to resources. I am concerned in particular about resource transfer; there is a lack of clarity on what happens to resources once they go to the local authority.

Over the years, we have heard frequently from our members that savings from mental health closures were being redeployed into other branches of medicine. Strong and convincing political arguments can be made for developments in acute medical and surgical care, but mental health services have not as yet made those same powerful arguments. We are concerned that, at times, money can go to other aspects of health care. As I said, if the money goes to the local authorities and it is not ring fenced, it is not always possible to track whether it is spent on mental health services.

The Convener: Does any other panel member think that the money should be ring fenced? It seems that nobody else agrees. We will move on.

Christina Naismith: I have a comment on resource transfer. I will also pick up on a couple of other issues. Any resource transfer that a local authority receives is fully accounted for. We are still accountable to the health board that made the transfer. There is never any dubiety on the matter because we have a clear accounting process, which is laid down in accounting practices; it is there for all—voluntary organisations or the public—to see.

I turn to ring fencing. Our experience relates to one piece of ring-fenced funding—the mental health specific grant. Only £20 million is made available for the whole of Scotland and difficulties are caused as a result. It is often difficult to eke money out of the local authority because it expects the money to come out of that pot. Although some authorities have augmented the fund to make the best of it, the number is few. The inherent difficulty when an authority ring fences money is that that is all that we get. For example, if we want to make needs-led assessments part of mental heath services, ring fencing may not be the starting point.

Derek Lindsay: My point is on ring fencing. At this morning's Finance Committee, the committee debated its cross-cutting expenditure review of deprivation report. One of that report's recommendations is that

"the Committee believes greater accountability and better effectiveness can be achieved by removing ring-fencing of resources allocation, giving local partners greater scope to identify local priorities and implement partnership outcome agreements."

Although the recommendation was made in a different context, the principle remains the same.

Dr Boyle: On ring fencing, I take a somewhat different view. The money that is allocated to mental health is allocated on the basis of the needs of the national population. It would be useful to have a clear idea of the allocation at local level. If the decisions to vary priorities according to local need were clearly set out, the process would be clear.

At the moment, it is not easy to get at the process. Table 3, "Proportion of total expenditure on mental health", is based on figures that I received from the various boards. Given that boards report differently, the figures may not be consistent. However, the assumption that I made was that each board reports consistently over time. The table shows that the proportion of total expenditure that has been spent on mental health has fallen in almost every board area. That might be the correct decision for the boards to take

having made an assessment of local priorities, but I throw the figures into the discussion, in order to open up debate. People around the table can make the case that that is how spending in their area should go.

My view is that these figures should be clearly available. When I asked the question, "How much are you spending on mental health as a proportion of total spend?" someone in the board should have been able to tell me that it was X, Y or Z for the year in question. I did not get that feel. Perhaps I do not know enough about Scottish mental health as yet, but I did not get that feel.

Janis Hughes: Some of the evidence that we have been given already shows that variation exists in the degree to which health boards are aware of how local authorities and the voluntary sector in their areas spend on mental health care. It is important that boards, local authorities, voluntary sector organisations and the other partners have that working knowledge. The joint future agenda had that aim, so the evidence that that may not be happening in some areas is a bit concerning. Are the current financial and organisational arrangements sufficient to allow close partnership working between health boards and the corresponding local authorities? If not, what would make it easier for health boards, local authorities and the voluntary sector to work together to improve the mental health of the people they are duty bound to help?

Christina Naismith: We are engaged in that process. Donny Lyons mentioned the delivery plan for mental health services. We have attempted to make that a plan that not only concerns how the health service will deliver, but that takes into account issues across the board. Shona Neil and I are involved in the national group that has been working on that plan, alongside a variety of colleagues. It is important that the delivery plan is not seen as simply for health services. We are still trying to work our way round that issue.

One proposal has been to use the joint future mechanisms, although we need other measures. For example, the Scottish Executive sets local authorities and health services different targets and we have different performance indicators and ways of measuring how our services are delivered. Traditionally, local authorities include older people's care as a separate stream of work and finance, but that includes a proportion of people who have dementia and other mental health problems in older age. There are different accounting methods, but we must overcome those issues, which is well understood locally.

In most board areas, if not all, joint strategies are in place, but those concern mainly adult mental health and only a few concern the mental health of older people or of people who are under 18. There has been a lot of concentration on joint working in relation to the main adult population, but less work has been done on services that are for people at either end of the population, which causes confusion. We must continue to work on that.

David Christie: I have two comments. The draft report goes into detail on the work of the choose life initiative and the funding that has been made available locally for that. Those local partnerships are an excellent example of how voluntary organisations and statutory bodies can work together effectively. The issue is not only about the provision of money; it is about finding new ways of working.

My second point is a query. When we talk about total expenditure, are we talking about only statutory money or about funding for mental health work by voluntary organisations that does not come from the statutory sector? For example, funding might come from charitable trusts or voluntary giving.

The Convener: We are scrutinising the Executive's budget, so our principal interest is in the money that comes from what we might call small-g governmental sources rather than third parties, although that is not to say that we cannot consider such funding. Indeed, that is what our current questions are really about. We are aware that there is voluntary sector spend, but a lot of voluntary organisations get their money from Government sources, too. We are trying to tease that out.

Shona Neil: I will pick up on the issue of voluntary sector spend. To make a point similar to the one that Christina Naismith made in talking about resource transfer, voluntary organisations' accounts contain a breakdown of which money comes from local authorities and which comes from the national health service. If somebody had the time and energy, it would be possible to unpick that information. It is just like the situation with local authorities: there is no universal, Scotland-wide way of gathering and measuring that information, and indeed of measuring the output for that investment.

14:30

David Christie made a good point about the choose life programme, which is a good example of relationships up and down the country. Unfortunately, the vast majority of work between the voluntary sector and the statutory sector is delivered under contracts that are put out to compulsory competitive tender. For a number of years, SAMH has raised the fact that the contract culture was abolished in the health service because it was seen as inefficient and

bureaucratic, yet it continues to operate in local authorities and the voluntary sector. Elements of the contract culture work quite well, but it is bureaucratic and inefficient, and we still suffer from the long-term cost of short-termism. In spite of talk about best value and three-year funding regimes, many voluntary organisations are still operating on year-long contracts, which make long-term planning and long-term costing quite difficult.

The Convener: You made a point in the first part of your answer about the difficulty of identifying all the bits of expenditure. That is the point of this exercise. Clearly, we are trying to assess the effectiveness or otherwise of mental health expenditure in Scotland. If we cannot always identify the mental health expenditure, it can be difficult to say whether it is effective.

Derek Lindsay: On resource transfer, the route often ends in voluntary organisations. For example, the closure of adult mental health continuing care beds in Ayrshire resulted in a resource transfer to local authorities, which then contracted a voluntary organisation to provide that care in the community. It might be worth the committee considering the level and total value of resource transfer, which has been increasing year on year. At some point, a vote head change from the health budget to the local authority budget will be appropriate. There is dual accountability at the moment: health boards have to account for the money that they are voted and local authorities have to account for the money that they are given by health. There is a chain.

Allyson McCollam: I wish to follow up a couple of points that others have made, one of which is the link between national strategic goals for mental health—what we would like to see in Scotland—and what happens on the ground locally. Some of the more innovative developments that we are aware of as an organisation have occurred where a clear national framework has been set, with expectations, standards and targets, and there has been freedom and discretion for local service systems—the NHS, local authorities and the voluntary sector—to work together towards those standards and targets. The state of the art in mental health is such that it is quite difficult to track the relationship between costs, quality of care, quality of service and outcomes, in terms of the impact on individual service users and their families. Although that information is available for some specific services, it is not necessarily available for whole local mental health service systems.

Janis Hughes: Have the health board representatives found the development of extended local partnership agreements helpful in encouraging joint priority setting and funding with the local authorities in their areas?

Anne Hawkins: My experience of the partnership agreements was in my previous role in NHS Forth Valley and I found them helpful and positive.

I wish to comment briefly on resource transfer and to pick up Derek Lindsay's point. I do not agree that resources should be transferred to local authority budgets. The money that is spent by local authorities and health services should be part of one overall pot that we work to manage together. The whole ethos of community health partnerships or community health and care partnerships—whatever they might be—should be about joint management of those budgets. How that is done is another question.

Derek Lindsay: I do not disagree with Anne Hawkins. On extended local partnership agreements, I would put explicitly on the table how much health and local authorities are investing in mental health, so that it is visible for the first time. The next step from that is shared budgets, pooled budgets and so forth, as Anne Hawkins describes.

Peter Williamson: Briefly, I agree with both my health board colleagues. However, it would be helpful to have clear targets—perhaps they will come out of the mental health delivery plan. It is difficult to set targets in mental health, but other areas of health care have shown that targets can deliver change if they are properly thought through, used correctly and supported with funding. Mental health services could do with that drive.

Dr Lyons: I back up what Shona Neil said earlier. From the many dealings that I have had with voluntary organisations, I know that they suffer severely from short-termism. That is a major problem for people who are offering an important service.

The Convener: We probably all have experience of that.

Kate Maclean: Convener, I have a question on something that has just been said.

The Convener: Let us try to deal with it as quickly as possible.

Kate Maclean: All the health board witnesses have said that they support the use of one pot of money for mental health services and, I presume, for other services. Who would be accountable for that money and who would decide how it was spent?

Anne Hawkins: To give an example, in Glasgow we have created a mental health partnership, which we are extending to the Clyde area. The mental health partnership's committee

will be accountable to the health board and to Glasgow City Council and the other local authorities. In effect, the local authorities and the board will vest their authority in the mental health partnership for three strands of responsibilities: strategic planning, performance management and the direct management of some regional services that we have decided should continue to be managed on a Glasgow and Clyde-wide basis for the moment, but which will ultimately become the responsibility of the community health partnerships.

Kate Maclean: However, will the constituent bodies still be ultimately responsible for the decisions about how much money they put into mental health services?

Anne Hawkins: Yes.

Euan Robson: We touched on this a little earlier, but I want to spend a few moments asking about the shift from acute to community-based mental health care. Clearly, all the boards are going in that direction, although they start from different places, with some being more advanced than others. Our adviser's report gives some measurement of the reduction in the number of acute beds and it gives other information on how that shift is taking place, but how do boards measure that shift from acute to community-based care? Should it be measured? Should we have a standard way of measuring such changes so that we can see how the policy is progressing? What is the balance between the additional costs that are incurred and the savings that are made with the move from acute to community-based care?

Derek Lindsay: On the first of the two points raised, one way to measure that shift is in terms of the spend, or resources, that have been transferred from hospital-based to community-based services. For example, over the period, NHS Ayrshire and Arran has had a 50 per cent increase in community-based care costs and a 100 per cent increase in resource transfer. That reflects the shift in services. Community-based services tend to be more expensive, so care in the community is not a cheap policy. Particularly for adult mental health services, significant costs can be associated with care packages.

Allyson McCollam: I want to clarify that the distinction between acute services and community services is not necessarily the right one. Increasingly, acute care can be delivered in the community by a range of different community-based teams. My point is not just about the words. We need to find how to collect the information in ways that reflect the fact that a fair amount of evidence shows that community-based responses can be effective for people who have acute periods of mental illness, but they may be fairly costly.

We also need to be clear about the range of functions that we expect to have in a reasonably well performing community service. The delivery plan is looking at setting out some of those functions in more detail, but it will clearly be important to be able to track them over time. We still do not have enough cost information behind that to give sufficient reassurance about equity and quality of care throughout the country.

The Convener: On your initial comments, are you saying that the way in which information is collected means that it does not reflect the reality of the new way of delivering mental health care?

Allyson McCollam: I suspect that it does not. The information might not have caught up with the situation yet. However, health board colleagues might be better able to respond to that point.

Peter Williamson: I want to confirm what Derek Lindsay said. We measure the shift from community care, and to an extent set targets for it, by spend. However, that is on the input side. There is a question about the output side.

One difficulty is that we do not have information systems at the moment that can capture all the activity that happens in the community, whereas it is relatively easy to measure in-patient episodes. When in the community, people obviously have contact with a number of professionals, either in their own homes or as attending out-patients, and it is much more difficult to assess that. There is an information gap around tracking what is happening to people.

We do not want to get too hung up on the hospital-community divide, although there are issues around that. We have relied too much on in-patient care in the past and we still do to an extent. It is important to be able to offer people a complete range of services for their needs, which may include in-patient care. We should not get into just regarding hospital care as potentially bad and community care as good. The point is to meet people's needs effectively across the spectrum of services.

Anne Hawkins: We must be careful about the assumption that community services are more expensive than hospital services. If we are looking at closing long-stay beds, which are at the cheaper end of the spectrum, and investing in community services, it is probably the case that the latter are more expensive. However, as I said earlier, I worked recently in NHS Forth Valley, where we developed a whole treatment service that used the mental health joint local implementation planning moneys as transitional funding to get the service up and running. It ran for about three months and our usage of acute beds dropped rapidly as it was running. People really

wanted the service, which was part of the response to crisis and avoiding admissions.

Within six months, we were able to close something like 35 acute admission beds and a service was being provided locally that responded to local people's needs and demands. That was also part of a move to one admission site, which fitted in with demands around junior doctors staffing and so on. A community service does not have to be more expensive and it can meet need and demand.

The Convener: Are the health board witnesses—who represent a corporate view—content that the changes that they have instituted, particularly the sort of service about which Anne Hawkins just spoke, are generally accepted by the public?

Anne Hawkins: The developments that are taking place in Glasgow are about early intervention services, increased crisis services and so on, and the final stage of development is taking place this year. They are responses to demands that the public have expressed. Seán Boyle's report refers to the report that Sandra Grant produced in advance of the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003. Sandra Grant's report refers to focus groups in which the public requested certain services. Everything that we have put in place in Glasgow has been to meet the public's needs and demands. I am comfortable that that is the case. I cannot say the same about the Clyde area yet, but our aim is that that will also be the case there.

Derek Lindsay: In the mid-1990s, a discharge programme for adults commenced in NHS Ayrshire and Arran, and about 70 beds closed. When placements were identified for the discharged people, the initial reaction from some of the public was, "Not in my back yard." However, there has been a full evaluation of the programme and, from the perspective of users and those who moved out, the change has been rated favourably. In addition, the programme has become much more accepted by the general public.

14:45

Peter Williamson: In designing and developing new services in the past few years, we have consciously involved users and carers and also consulted the wider public. Although there are different views, we have had a fairly high level of support from users and carers for the direction in which we are going. Perhaps inevitably, there are concerns about some services, but we are seeking to rectify those. People broadly support the direction of travel and they want the type of services that Anne Hawkins mentioned—responsive services that are quick off the mark and are located in local communities rather than entailing hospital admissions.

Allyson McCollam: We should not think only about people who require acute in-patient care and long-term community-based services, because there is a wide range of mental health needs in the community. The work that is happening throughout Scotland is evidence of the growing capacity of primary care services to respond to people who have what are sometimes called mild-to-moderate mental health problems.

We have been involved in innovative evaluative work that shows that the public are interested in short-term interventions whereby they can get ready access to the right level of professional expertise to match their needs. People do not always have to go right into the system to get highly specialised services. There is an increasing number of examples of innovative practice that are immediately accessible to people.

The Convener: People are putting their hands up. I point out that the Deputy Minister for Health and Community Care is due to come in at 3 o'clock. We do not want to delay him, so we are slightly pushed for time.

Shona Neil can come in briefly, then I will go back to Euan Robson. I ask him to keep his line of questioning to about 3 or 4 minutes.

Shona Neil: Some good examples of crisis intervention have been highlighted. It is important to note that the vast majority of people do not end up in the hospital system, but are treated in the community. We should recognise, however, that people with mental health problems still have remarkably low expectations of what services will provide for them. Some people are prepared to settle for poor services for fear that they will lose them. We need to identify the problems and find ways to get people to comment critically on local services without being afraid that they will lose them and have no service at all. People will say that a bad service is helping them just because they are afraid that they will lose it. It is important to be able to discern between—

The Convener: Assent is being signified by Donny Lyons, whom I will bring in during the next group of questions.

Euan Robson: If we accept the general point that we want services to be transferred away from large acute hospitals to community-based care, what difficulties can hinder that move? We identified resources as one such difficulty. It is also difficult to identify data; there are low expectations; and there are problems with local reactions by the general public to the prospect of community-based care. Are there any other factors that hinder or delay the general shift to community-based care? Also, will the mental health delivery plan provide a

better framework for implementing the mental health framework?

Peter Williamson: I hope that the plan will develop further in the coming years, but it is a step forward because it provides a central drive and a consistent understanding of what needs to be achieved.

Allyson McCollam: The plan has great potential to do that, but it is critical to ensure that local authorities and the voluntary sector are fully involved and that the plan is not seen as something that is owned and driven solely by the NHS.

Shona Neil: I agree that the delivery plan has huge potential, but at the moment it lacks ambition and it picks up on things that were already in train. Allyson McCollam's point is critical: other people need to buy in to the plan and it needs to provide a clear vision of what benefits we expect for service users and their carers.

The Convener: We move on to discuss the implications of the Mental Health (Care and Treatment) (Scotland) Act 2003. There are two aspects—the development of infrastructure to administer the act and the development of services to implement the spirit of the act—both of which have resource implications, particularly for health boards. As far as we understand it, most boards feel that the 2003 act provides either financial or physical resource challenges—or, more likely, both—and that, at present, insufficient resources are available to implement it. The Scottish Executive has made funds available to health boards and local authorities, but it is not perfectly clear to us how those sums were determined or whether they are sufficient.

I want to focus on those issues for 10 minutes, to get your views on the main problems that health boards face. Are inadequate funds the problem or is the issue a lack of key human resources, such as consultants? What are the main benefits that you expect to arise from the implementation of the 2003 act and how are they being measured? It might be too early to say, but do you have any feelings yet about improvements?

Peter Williamson: The 2003 act is to be welcomed. It presents resource challenges, but it is important to stress that it takes mental health services in the direction that NHS Tayside hoped for.

The Convener: I ask people not to do the public relations bit. I appreciate that you all want to preface your remarks with a bit of PR, but can we cut to the chase?

Peter Williamson: Right. The act reflects the direction in which boards were developing their mental health services, but there were always going to be resource challenges. The key issue for us has been the administration of certain parts of the act and the time that that has taken for responsible medical officers and mental health officers in local authorities. That is largely a result of the work of the Mental Health Tribunal for Scotland, which is much greater than we expected.

The Convener: So the issue is one of physical resources.

Peter Williamson: Yes.

Derek Lindsay: We are trying to deal regionally with some of the resource implications, with all health boards contributing. For example, medium-secure forensic facilities, perinatal beds and adolescent mental health in-patient beds are best delivered regionally. Local resource challenges also arise. Obviously, consultant time is taken up with involvement in the tribunal and we also require extra accident and emergency liaison psychiatry and additional nurses. Significant financial challenges arise as a result of the implementation of the 2003 act. From a human resources point of view, in Ayrshire we find it difficult to recruit child and adolescent mental health consultants—we have had three or four vacancies for about three years and we cannot recruit. Funding was made available to health boards and local authorities to implement the 2003 act, but I understand that it is non-recurring and therefore cannot be used to recruit people to permanent posts.

Anne Hawkins: NHS Greater Glasgow and Clyde welcomes the 2003 act, which fits with the overall implementation of the mental health framework. We were prepared for the implementation of the act and had money associated with it, so that has not presented any problems. The administration of the processes that are associated with the Mental Health Tribunal for Scotland has caused us problems, which we are pursuing. A longer-term issue that may need to be considered is the role of consultants in relation to the 2003 act. Over time, we will not have sufficient consultants to resource the act, given the way in which the mental health consultant workforce will change.

I agree whole-heartedly with Derek Lindsay's points about the non-recurring money that was allocated to health boards. That poses problems for us, because we have individuals in post but we will have to redeploy them if the money is not continued.

The push towards regional services is positive. For smaller specialties such as child and adolescent and forensic mental health services, that is the only way for us to go.

The Convener: Did you get enough money to implement the 2003 act?

Anne Hawkins: We did, because of the care approach in Glasgow.

The Convener: Did NHS Tayside get enough money?

Peter Williamson: To implement the act, yes.

The Convener: What about NHS Ayrshire and Arran?

Derek Lindsay: We must prioritise it out of our general allocation.

The Convener: So the answer is no.

Derek Lindsay: There is sufficient money in the total pot.

Dr Lyons: One point is the opportunity cost of people being taken away to do tribunal work.

I will spend one second on PR. I have accurate statistics on mental health detentions throughout Scotland over the past five years. The committee's figures are not accurate. If you want to know the accurate figures, ask the Mental Welfare Commission for Scotland, as we always keep them.

So far under the Mental Health (Care and Treatment) (Scotland) Act 2003, emergency detentions have gone down and few people have been subject to compulsion—about 12 or 13 per cent less than under the previous legislation. That might be due to better investment in community services and psychiatric emergency plans. Boards across the board—if I can say that—are to be commended for that.

A big concern for us is that far too many young people are still being admitted to general adult wards throughout Scotland. It is not a matter of throwing beds at the problem; it is about providing good crisis services for young people with mental health problems who get into difficulties.

I will make a quick comment about tribunals and opportunity costs. One of the problems with tribunals has been the multiplicity of tribunals for each case. The chairman of the Mental Welfare Commission is doing some work to try to, for example, speed up the appointment of curators ad litem.

One thing that will definitely help is better investment in information technology infrastructure to allow better and quicker transmission of data. That will help the whole system for the 2003 act to work. If I could make one plea for investment, I would identify that as an important area in which to invest.

The other point that I will make goes back to the previous point, and I want to link them up. We now have compulsory treatment in the community. We must back that up with community-based services that assist people in the recovery process. We must not only have services that compel people to take treatment; we must do something far more active than that. That is a major issue that requires investment.

Anne Hawkins made a point about long-stay care being relatively cheap. It is relatively cheap because it is not very good. It must not be forgotten that as you contract long-stay care, a greater proportion of people with the greatest need stay in hospital and unit costs go up. The Mental Welfare Commission sees some very poor quality continuing care. People sometimes have to live their lives on contracting sites and building sites that they cannot get around and cannot exercise in. People are still living on wards with run-down fabric, which will close, but goodness knows when.

Christina Naismith: The first point that I want to make, convener, is that you drew attention to the two strands of work around the Mental Health (Care and Treatment) (Scotland) Act 2003—infrastructure and services. The Mental Welfare Commission should acknowledge that those are not exclusively run by health services. When it commends boards it should also commend local authorities for introducing a complicated act, which we all supported. We were all around the table for many years developing it. We probably want to congratulate the Parliament on allowing that—

The Convener: Can we stick to the budget issues?

Christina Naismith: The budget issues are that local authorities have had to shoulder a lot of the pain and find a lot of the budget. The work got money on an on-going basis, but I accept that that did not happen for many health colleagues.

We are not yet at the stage of knowing exactly what is happening. A number of pieces of work have been undertaken to examine the impact of the 2003 act, but it is complex to examine the full development of services that prevent people from coming within the ambit of the act. Some costs are definitely associated directly with the act, such as the building of new units for forensic care and perinatal units. Once we get past those, we come to the services that enable people not to need to be compelled into treatment. Those services are much more broadly based and are the kinds of services that might be referred to in the paper that Shona Neil mentioned. At our peril do we concentrate on the high cost—

The Convener: Right now, we are trying to concentrate on what we can identify. That is the problem.

Christina Naismith: I think that that is the easy bit.

Shona Neil: I agree. The Parliament's research programme on the 2003 act is scheduled to end in 2008, but it is crucial that it continues beyond then, until we get a handle on what is happening under the act. We still have a concern about the unintended consequences of the act, because it might mean that more resources are prioritised towards treating people who are detained than people who are being treated informally. That could lead to the development of a two-tier system, which we must guard against.

I wholly endorse Christina Naismith's point. We have talked a lot about the funding of services for people who already have a mental health problem. That is important, as people deserve good services that help them to recover. However, we also need to continue to put money into promoting mental health and well-being for everybody in Scotland, in order to build a resilient community of citizens.

15:00

The Convener: We have had to do a brisk canter through all that because of our externally imposed timetable. As I say to everybody when they leave these sessions, if anything occurs to you that you wish you had added or feel could amplify the information that we already have, such as the talk about detentions that you have raised, you are invited to send it to the clerk after the meeting. I thank you all for attending. You are welcome to stay on for the next half hour while we take evidence from the minister.

I welcome the minister to the continuing evidence session on the mental health budget. We will move straight to questions; we do not have much time and we want to give the minister a few minutes between this session and the next one. I propose to run this session until half past 3, when we will have a brief suspension. I wish to discuss for a few minutes the general question of the allocation of expenditure to mental health budgets. From where you are sitting, do you see a large variation between boards' expenditure on mental health? If you do, is there an explanation that is obvious to you?

The Deputy Minister for Health and Community Care (Lewis Macdonald): The Executive does not see an unreasonable variation. Our view would be that we make the funding available to boards in order for them to determine their priorities in relation to the health care needs of their local populations. A range such as the one that the committee has considered seems to us reasonable.

The Convener: You think that it is a justifiable range.

Lewis Macdonald: There is bound to be a degree of variation between areas.

The Convener: Very superficially, what are the factors behind the degree of variation?

Lewis Macdonald: In round terms, there are a number of factors, including the health needs of the population and the nature of the infrastructure. For example, the expenditure profile of boards that are still dealing with the older psychiatric hospital type of infrastructure, with a significant number of beds, is different from those that have made more progress towards care in the community. That variation is inevitable and reasonable.

The Convener: But you are content that there is nothing particularly out of the ordinary.

Lewis Macdonald: In broad terms, yes. Clearly, there are other aspects, relating to deprivation, age, gender and so on, which may have an impact too.

The Convener: In global terms, what has been the increase in spending on health care in Scotland since 1999-2000? How much of that would you consider to have gone on mental health care?

Lewis Macdonald: In global terms, spending has increased from £4.9 billion a year in 1999 to £9.5 billion now. Broadly speaking, spending has doubled over that period. By next year, the figure will be nearly £10.3 billion. Over a similar period, to 2004-05, there has been an increase in mental health expenditure of the order of 43 per cent, taking the direct spend by boards to £625 million, with a further £62 million in that year in resource transfers. In rough terms, it is £700 million.

The Convener: Why does our understanding of the mental health budget increases go up only to 2004-05, when you are talking about the general health budget into next year?

Lewis Macdonald: If you give me a moment, convener, I shall reach into the depths of my records and see whether I can give you a more up-to-date figure. It is in the same broad area. Geoff Huggins may have the figure more readily to mind.

Geoff Huggins: The 2004-05 figure relates to outturn. The reports that you have been receiving are in respect of outturn against mental health expenditure whereas the overall budget allocation figure is a forecast, or the commitment. That is why one will be running after the other.

Lewis Macdonald: We do not yet have the published outturn figure for 2005-06, for example.

The Convener: Does anyone have specific questions on the generality of this issue?

Shona Robison: I would like to ask about the monitoring that the Scottish Executive does or does not do. The adviser's report concludes that attempts to monitor the degree to which mental health funds have been routed to mental health are ineffective. How do you ensure that the money that is allocated at the centre reaches the services?

Lewis Macdonald: It would be fair to say that we do not pretend to have absolute chapter and verse on that process. Having seen some of Dr Boyle's preliminary work on that, we will look at the committee's report with great interest, to improve our measurement further.

Jane Davidson has responsibility in the department for monitoring the spend. It is of course for boards to make that spend.

Jane Davidson (Scottish Executive Health Department): We can see the spend in historic terms. Because it is wrapped up in the overall board allocation, it is based on health board determination, which is what it comes back to. The question relates to what the service need is going to be.

Shona Robison: Yes, but do you not think that something a bit more robust is required, given that new legislation is passed and new policies are developed that require the resources that go with them to reach the service? You are relying on health boards to do the right thing, despite the pressures they are under and the competing demands on them, but how do you know what is happening?

Lewis Macdonald: We accept that we need to know more. As Jane Davidson indicated, we look to boards to make judgments about their needs. To be sure that the funds are being used to deliver the objectives that we want them to deliver, we will take forward work on benchmarking in the context of the delivery plan. That is a significant change in our overall work to secure the mental health spend at a local level.

Kate Maclean: Are you surprised that the proportion of expenditure on mental health has reduced quite significantly in all but one health board area?

Lewis Macdonald: I am not entirely surprised. There has been a significant uplift in the level of expenditure on mental health and the statistic that you describe reflects the fact that there has been an even more significant uplift in the overall health spend. That takes us back to the convener's initial question. We have indicated to boards that this is a national priority and, accordingly, that we expect them to deliver it. We expect the mental health delivery plan to help them do that better.

We recognise that our investment in mental health has not quite kept pace with the overall increase in health spending, but it is definitely going in the right direction.

Janis Hughes: One of the assumptions that could be drawn from the budget increase that is shown in table 3 in the adviser's report could be that more care is being provided in the community, which means that local authorities' spend has increased. Can you tell us how much is spent by each local authority?

Lewis Macdonald: I do not have the figures for each local authority in front of me, but I have the total figure, which is about £95 million in the coming year. That includes spend under a number of headings within their overall expenditure.

I have been interested to see the efforts the committee has made to track some of the figures; it is clear that there is some ambiguity. The fact that such provision for local authorities is made within grant-aided expenditure rather than through ring-fenced funding means that tracking the outturns is not as straightforward as it might be if the funding were ring fenced. Perhaps Jane Davidson can comment further on the financial aspects of local authority spend.

Jane Davidson: I do not really have anything to add. We recognise the difficulty of keeping track, but we have started to work with our finance colleagues on that.

Janis Hughes: Are you saying that we can be given only a global figure? It would be helpful if we could see whether the decline in health board spending was reflected by an increase in spend by local authorities, but we could do that only if we had a breakdown of the figures.

Jane Davidson: I think that local authorities have a cost book that is similar to that for health boards. We should be able to source that for the committee.

Lewis Macdonald: It should be possible to provide the after-the-event, or outturn, figures.

Janis Hughes: I want to ask the same question about voluntary sector spend. Can we be given a figure for voluntary sector spend? Can we be given a breakdown of that?

Lewis Macdonald: I do not think that we have a figure for that.

Janis Hughes: Is there no global figure available for voluntary sector spend on mental health care?

Lewis Macdonald: No.

Janis Hughes: Is such a figure available from any another department?

Lewis Macdonald: We can certainly have a look and talk to colleagues elsewhere in the Executive. By its nature, voluntary sector spend is fairly diverse and dispersed.

The Convener: It is fair to say that voluntary sector spend will often be from funding that originally came from local authorities or health boards, so we would need to be careful not to double-count the figures.

Lewis Macdonald: Indeed, we would be keen to avoid that.

Helen Eadie: The evidence that we heard earlier this afternoon suggested that although the contract culture has been abolished in the NHS, voluntary sector organisations find that the same is not true of local authorities. Will the minister look into that? That seemed a reasonable point.

Lewis Macdonald: Aspects of that go beyond my area of responsibility. Over the piece, we seek to continue to engage voluntary sector organisations—and, indeed, local government—as key partners in the delivery of mental health services. Many of the efforts that we are making are about better joining up of those delivery agencies. In terms of contractual relationships, I am not sure that I would add anything specific at the moment. I look to my colleagues for their thoughts on the matter.

Geoff Huggins: Much of the support that the Scottish Executive Health Department offers directly to voluntary organisations is in the form of grants made under section 10 of the Social Work (Scotland) Act 1968 or section 16B of the National Health Service (Scotland) Act 1978. Equally, local authorities provide grants and enter into contracts. There is a mixed economy that depends on the nature of the service being funded. The picture is not one of all or nothing, as was perhaps described.

Helen Eadie: Convener, perhaps we can hear about that at a later date from the organisations concerned

The Convener: Okay, but I do not know that we have much time to go into that as part of our budget scrutiny.

Mr McNeil: The figures in our adviser's report obviously carry a health warning, but the story that they tell is "variation … variation … variation". That is of concern to us all. The minister accepted that there are variations, but he suggested that they might not be outrageous. I note that he did not say that the variations are raising questions. I take it that that is the case.

What more can you tell the committee about the work that is on-going? Is the purpose of that work just to tackle the budgets? Did you say that the Executive is engaged in on-going work?

Lewis Macdonald: Yes.

Mr McNeil: I was going to put the question to Jane Davidson, but she was looking somewhat sceptical. Is there work going on, Jane?

Jane Davidson: I think the work is in relation to the mental health delivery plan.

Mr McNeil: How would that relate to addressing the variations that the committee is worried about? I am talking about budgets, delivery of services, the cost of prescription medications and so on, right across the board.

15:15

Lewis Macdonald: The mental health delivery plan should indicate to all those involved in providing the services what the services should look like. It creates a framework. Work in the health service in recent years around physical illnesses that have been recognised as national priorities has involved using managed clinical networks and other mechanisms to address those particular ailments and increase the ways in which boards can tackle them effectively. The mental health delivery plan is intended to do the same in relation to mental health areas. Geoff Huggins might like to say a little more about how that will work and where we are with it.

Geoff Huggins: We are getting to the end of the process of developing the plan. A number of the earlier witnesses were involved in that process. The benchmarking work is interesting and is part of a wider piece of work on national benchmarking. In the area of mental health, we are looking at financial spend by health boards and local authorities, as well as activity and prescribing. Looking at one indicator or set of figures on its own does not tell us much. It is only when we see the indicators for community activity, hospital beds, expenditure and prescribing in combination that we begin to get a picture of the nature of the different services. That is not to say that we know what the right answer is for any of those areas, but we can engage with them and try to understand what is happening on the ground, which is the issue that the committee has identified today.

Mr McNeil: Will the work consider best value and best practice? Will it evaluate what is in place? Will it put monitoring systems in place? Will it consider issues such as targeting, as well as joint budgeting and working between local authorities and health boards?

Lewis Macdonald: It will broadly do most of those things.

Geoff Huggins: That kind of work will sit alongside the plan, which is about creating the information with which we can work. It is about

filling the information gap, which the committee identified earlier as an issue, and getting an understanding of the different activities in which each board is engaged.

Mr McNeil: Will that report be available to the committee?

Geoff Huggins: All the information about the delivery plan is on the Health Department website, so we can give you what information is available on benchmarking from that. However, work on the benchmarking project will continue over the next two to three years. It is intended to create a data source that runs from year to year. I would hope that more people than you would want to access that to gain an understanding of what is going on.

Euan Robson: Has the Executive identified factors that hinder the move from large acute hospitals to community-based care? What is your observation on that, minister? Is there any danger of losing sight of actually improving acute provision for those who need it? In other words, if we all concentrate on one direction, do we run the danger of losing sight of the other direction?

Lewis Macdonald: There is no general answer to the question about factors that make the process difficult, because local circumstances vary. We have made the direction of travel clear to boards and it is for them to make the determination at a local level of how they deliver that. However, the indication to them that they should be making that movement is continuing and we would look for further progress on that. Again, Geoff Huggins might know whether there are particular issues that are causing difficulty for individual boards. However, none has come to me as a showstopper.

Geoff Huggins: We have just known for a long time that it is difficult to make the change from one form of service to another while keeping care going for the people who receive it.

Euan Robson: What about those for whom community-based care is not appropriate but who need acute provision?

Lewis Macdonald: Absolutely. In a sense, part of the point in making the move to community care for those who do not need continuing acute care is to allow, for example, acute psychiatric services to focus on the patients who do have a continuing need. That is certainly one of the changes that we would expect to see. Again, in the context of the mental health delivery plan, we would expect to lay down indicators as to how that should happen.

The Convener: I have a few questions about the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003. You might have heard our discussion about that earlier. How did you estimate the amount of money that health boards and local authorities require to implement the act? Will you comment on the fact that the money for the health boards is non-recurring whereas the money for the local authorities is recurring? Is there a technical reason for that? We would appreciate an explanation.

Lewis Macdonald: I ask Geoff Huggins to comment on how the estimate was made.

Geoff Huggins: It was difficult for us to assess what would be required to assist with implementation. We identified a number of areas in which we knew that work would have to take place.

The Convener: Do you mean geographical areas or sectoral areas?

Geoff Huggins: Sectoral areas. There were training needs; it was expected that advocacy would increase; there were expectations around child and adolescent services and perinatal services; and we anticipated the need for more mental health officers in local authorities and more approved medical practitioners, who are consultant psychiatrists with particular qualifications.

Work is in hand to assess the impact of the act, but we are trying to understand its cost implications in practice. We can plan and make assessments and judgments, but things do not always end up as we expect.

The Convener: Does that mean that the original estimate was a bit of a guess?

Geoff Huggins: There were certain elements that we were able to assess, such as training—

The Convener: You have just confirmed what we already think.

Geoff Huggins: To describe it as a guess would be rather unfair. We could assess the training element and we had some idea of expenditure on advocacy, but there are other elements on which we were less certain. As you heard today, the boards considered it a fair estimate.

The Convener: A fair estimate as opposed to a guess.

Lewis Macdonald: It was the best available estimate, I think.

The Convener: What about the implementation funding for health boards and local authorities, which was granted on different bases, one being recurring funding and the other being non-recurring?

Geoff Huggins: The resource that is paid to local authorities is paid through grant-aided expenditure, but we offered the resource to health boards as a top-up to the allocation. At present,

that is funded through to 2008. We have not said whether we will continue to pay it beyond 2008. We will need to assess whether all the additional costs are, in fact, recurring costs. We knew that the cost of additional mental health officers in local authorities would be a recurring cost, but we are not as clear that all the costs that fall on boards will recur in the same way. There was a degree of prudence in our approach.

The Convener: So the health boards will have to provide evidence that the costs are recurring.

The point has been made that the impact of the act is being seen already in pressure on physical resources. For example, there are concerns about consultant vacancies and the pressure that is being put on certain aspects of the service to deliver on the ground. Can a way of handling that be factored in?

Lewis Macdonald: Again, we need to consider the evidence as it comes through. The committee's inquiry will help us to make that assessment. It is fair to say that, with new pieces of legislation, we sometimes have to use the best available estimate and review it when we have seen the impact on the ground. Given where we are in the spending cycle, this is a relatively convenient time to review the actual spend and costs and to plan for any additional investment that might be required.

Dr Turner: How much money was set aside for the information technology infrastructure so that people can communicate in multisystem working? We know that there is a lack of standardisation—for example, there are different definitions of out-patient.

I asked Allyson McCollam a question earlier and it seems that ISD Scotland collects information, but how do you see the way forward with IT? It is important to get the information back quickly. There is a similar situation with the lack of consultants. It takes time to train the consultants who are needed to provide the service we hope to give.

Geoff Huggins: We have invested in IT directly through the Mental Welfare Commission's systems and the Mental Health Tribunal for Scotland's systems. They are liaising with boards and local authorities to find out whether they can use electronic transmission of forms to improve the process.

The wider picture is that we are keen not to create a separate mental health IT system because many of our patients are also patients of the wider system. It is important that they have access to the full range of services and are not ghettoised by being part of a separate system. We hope that the mental health systems will develop and take the benefits from wider improvements in information systems throughout the NHS.

Dr Turner: Does that mean that we have to wait until you organise a bigger system?

Lewis Macdonald: That work is continuing throughout the system, in relation to the use of community health index numbers and our general approach to e-health.

Geoff Huggins's answer to Jean Turner's question highlighted an important aspect of mental health spend, which is the fact that a significant element of it is not accounted for separately. A figure that caught my eye when I was considering the information before today's meeting is that 30 per cent of general practitioner visits in Glasgow are for mental health purposes. There is significant spend on those visits, but it is not accounted for separately as spend on mental health. The same applies to the infrastructure questions that Jean Turner asked.

Dr Turner: You mentioned the tribunals and the fact that there will not be enough consultants to service—

The Convener: Yes. It was indicated that there was greater pressure from the tribunals side of the implementation. That is pressure on time as well. I take it that such things will be monitored as we proceed.

Lewis Macdonald: Yes, indeed. There is a budget for the tribunals, but we want to monitor and work with them.

The Convener: Is there a separate budget for the tribunals?

Lewis Macdonald: Yes. The budget is £8 million this year.

The Convener: There do not appear to be any more questions. I thank the minister for coming for this session.

I will suspend the meeting until 15:37, at which point I will resume the meeting. Anybody who is not here at 15:37 will miss out.

15:27

Meeting suspended.

15:37

On resuming—

Adult Support and Protection (Scotland) Bill: Stage 1

The Convener: I bring the meeting to order, as we move to agenda item 4.

I should have said at the outset of the meeting that Nanette Milne has given apologies for her absence. I understand that she is at the seaside somewhere in the south of England. Sadly, there is no Tory substitute member on the committee.

We will now question the minister on the Adult Support and Protection (Scotland) Bill. We have allocated until 4.30 for questions so, having resumed three minutes early, we have found ourselves some extra minutes. I hope that, at the end of the 53 minutes, the minister feels that the extra three minutes have been used well. If all members have received a copy of the minister's letter—it was circulated late on—we can go straight to questions. The first group of questions will be from Kate Maclean, who has had a particular concern about the bill from the start.

Kate Maclean: I preface my remarks by pointing out that the fact that I am questioning the necessity for the bill in no way means that I am unconcerned about vulnerable adults or anyone else who is at risk of abuse. Despite any such perception, that is certainly not the case.

I thank the minister for his correspondence, which has answered some of my questions, but from my reading of the case studies that we asked for I am still not entirely sure what the bill will do that could not be done under other legislation, such as the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and existing criminal law. The first case study gives the example, which I think has been used before, of a vulnerable adult who has been pushed down the stairs. As the victim of a road-traffic accident, the person had received a payment, after which the person's ex moved back into the house. However, the person was being neglected and was pushed down the stairs. Why would that not be a case for the police?

Lewis Macdonald: If such a case came to the attention of the police, they would act because a criminal offence would have been committed. However, the bill was introduced to create powers for local authorities to access premises, for example, and to intervene effectively in advance of, or independently of, the production of evidence that a criminal act had been committed. The aim is to enable intervention in advance of, or independently of, criminal investigations by the police, although such investigations will clearly continue in circumstances such as those that Kate Maclean described. Additional legislation is required to ensure that powers of intervention exist and that local authorities know that they exist and will use them.

Kate Maclean: In the case study, the adult

"is adamant he does not want the police involved."

It seems to me that police involvement might be necessary later in order to enforce a banning order against the man's ex-wife. Indeed, there is nothing in the proposals that could not be done by using the criminal law and taking out an interdict to keep the ex-wife away from what I assume is the matrimonial home until other accommodation is found.

Lewis Macdonald: Given the reluctance of the individual to bring in the police, the police's ability to gather evidence in the case would clearly be limited without the local authority's having the right of access that is described in the bill. The purpose of the bill is to enable people to deal with circumstances in which the position under the current law is not clear.

Kate Maclean mentioned the possibility of taking out an interdict in situations in which a man or his wife is seeking protection from the other's actions. That could be done. Equally, common law interdicts existed for domestic abuse cases before Parliament decided in its wisdom to make special provision for domestic abuse circumstances or circumstances pertaining to matrimonial homes. The bill seeks to do the same for adults who are not covered by specific legislation but who are clearly at risk. A local authority's being given the power to investigate and make assessments can provide the basis for action by it, the police—in, for instance, the example that we are discussing—or other public agencies.

Kate Maclean: I want to take things a stage further. There is concern that the bill will lead to fewer criminal prosecutions. It seems that action would be taken in respect of some of the case studies that you have provided, but that there would not necessarily be a criminal prosecution. Would that be an acceptable unintentional consequence of the legislation?

Lewis Macdonald: I do not perceive a risk that there will be fewer criminal investigations; rather, I perceive the potential to uncover more circumstances in which people are at risk or are the subject of harm which were not previously uncovered, perhaps because the individual who is suffering the abuse does not want to involve the police. The act of uncovering abuse and protecting individuals does not of itself determine whether there will be a criminal investigation—there may or may not be such an investigation, depending on

the evidence that is uncovered. The bill's crucial achievement would be to uncover the abuse and—I hope—to provide protection to the adult in question.

Kate Maclean: In the case that we have been discussing, the person is disabled and uses a wheelchair, but does not seem to lack any capacity. Why would the powers that have been mentioned be appropriate in that case, but not in other cases?

Lewis Macdonald: I am sorry—which example are you referring to?

Kate Maclean: The one that we have been discussing.

Lewis Macdonald: Are you still referring to the first case study?

Kate Maclean: Yes.

Lewis Macdonald: Using the powers would be appropriate in any case in which an adult is at risk of abuse and is not receiving support and protection. The purpose of the bill is to provide support and protection.

Kate Maclean: So the powers could be used to support and protect any adult. If, God forbid, an ex of mine moved back in with me because I had won money on the lottery, would I be regarded as an adult who is at risk of abuse?

Lewis Macdonald: I do not want to go into that case in detail. As you know, the bill defines categories of persons who may be at particular risk and lists circumstances in which a person might be at particular risk. We want to find a means of identifying adults who are not covered by existing legislative provisions or on whose behalf public authorities do not think that they have a right or duty to provide assistance. That is the bill's purpose.

15:45

The Convener: It is typical for domestic abuse to continue for many years, during which the woman refuses to involve the police but most people around her know perfectly well what is happening. Why should such circumstances be not covered by the bill while others will? Why is a qualitative distinction made between that situation and others? In effect, you are saying that the situation of women who are subjected to domestic abuse—this might apply to other situations, but we are discussing domestic abuse—is not serious enough to be covered by the bill, so banning and removal orders and other measures in the bill could not be brought into play over and above the woman's decision to go to the police. Other categories of adult are, however, thought to be appropriate for inclusion in the bill.

Lewis Macdonald: The abuse of a person in a matrimonial situation is as unacceptable as abuse of an elderly person. The bill seeks to address gaps in existing provision. A number of measures protect people who suffer domestic abuse—particularly women—in addition to common-law provisions that afford a degree of protection—

The Convener: Such measures do not override a woman's decision whether to involve people. People do not say, "Okay. We've heard you say that you're not interested in being part of this, but we'll do it anyway."

Lewis Macdonald: In the bill we acknowledge that there are adults who have capacity but who, for one reason or another, cannot exercise a choice—

The Convener: For example, because they have small children and no money.

Lewis Macdonald: The bill defines categories of person who might be particularly at risk. The bill's purpose is to protect adults who are at risk; the categories are not meant to be exclusive. I am conscious that concern has been expressed to the committee that the bill takes an exclusive approach and that the way in which categories of people at risk are defined might cause a risk of unreasonable distinctions being made. The Executive will be happy to reconsider the matter before stage 2. Our purpose is to protect adults who are at risk of abuse, whatever the circumstances.

Kate Maclean: If two women who live next door to each other, one of whom is in a wheelchair, both suffer domestic abuse, the woman in the wheelchair would be covered by the bill's provisions, but the woman next door would not, even though their circumstances were almost the same.

Lewis Macdonald: As the bill is drafted, there is a risk of that being the case, which is why I said in response to the convener that we will be happy to consider the matter before stage 2. We want to make legal provision that will afford protection to both women in the situation that Kate Maclean described, if we can design the law to achieve that intention.

Kate Maclean: It has been suggested to the committee that an unintended consequence of the bill is that it could override provisions in other legislation: for example, it might override an advance statement that was made under the Mental Health (Care and Treatment) (Scotland) Act 2003, in which a person had stipulated that they did not want to be removed from their home. In such circumstances, who would decide which legislation would apply?

Lewis Macdonald: The bill provides for a test to be applied before a protection order can be made, and an advance statement would have to be considered. Section 2 defines the fundamental principles that will govern the added protection measures in part 1. It makes it clear that any person

"performing a function under this Part in relation to an adult must … have regard to … the adult's ascertainable wishes and feelings (past and present)".

In other words, if it is possible to ascertain an adult's feelings, they must be taken into account before any judgment is reached.

Kate Maclean: They must be "taken into account"—but they could be overridden.

Lewis Macdonald: That is the case, but subject to the usual legal provision of "have regard to". For example, a sheriff, in making a judgment, would have regard to the person's wishes and feelings.

Would that be an accurate description of the position in relation to a legal judgment being made on a person's express wishes, Kay?

Kay McCorquodale (Scottish Executive Legal and Parliamentary Services): Yes. If a sheriff was making an order, he would take into account the person's wishes, past and present, which would include their statement. However, that would not be the only thing that would be taken into account.

Lewis Macdonald: In other words, if there was clear evidence before the sheriff that the person, having made an advance statement and expressed their wish, was currently suffering abuse or severe neglect as described under the bill, the sheriff would give priority to relieving that suffering.

Kate Maclean: So that is a yes.

Lewis Macdonald: To what?

Kate Maclean: The person's statement could be overridden.

Lewis Macdonald: It could be overridden in circumstances in which the sheriff, in considering whether to make an order, had had regard to the advance statement and, on balance, his or her view was that the person's risk of suffering abuse would be increased by following the advance statement. In such circumstances, the requirement on the sheriff is to look after the best interests of the adult.

Janis Hughes: I have another question about the bill's interaction with other legislation. In the Adults with Incapacity (Scotland) Act 2000, there is no provision for urgent intervention. Under the Adult Support and Protection (Scotland) Bill, however, urgent intervention would be allowed. If an adult with incapacity needed urgent intervention, would the authorities use the bill to carry that intervention out, even though the person was covered by the provisions of the 2000 act? If that is the case, will the bill be good legislation?

Paul Gray (Scottish Executive Health Department): The question is about the interaction between the 2000 act and the bill.

Janis Hughes: Yes.

Paul Gray: Section 4 states:

"A council must make inquiries about a person's well-being, property and financial affairs if it knows or believes … that it might need to intervene in the person's affairs (by performing functions under this Part or otherwise)".

"Or otherwise" might, for example, relate to the 2000 act. The council might not know enough to be able to decide whether to intervene in a case using the powers under the 2000 act but, because there are no powers of urgent intervention in that act, might use the power in the bill to determine whether to intervene. The bill's powers serve as a gateway by opening up to a council the ability to determine what other legislation it might use. Following an assessment, a council might determine that the person needs something by way of care under the provisions of the Social Work (Scotland) Act 1968, for example, or something that is offered under the Adults with Incapacity (Scotland) Act 2000. The bill provides a gateway that the council would not otherwise have in order that it can make that urgent assessment.

Janis Hughes: I presume that there is a reason why there is no facility for urgent intervention under the Adults with Incapacity (Scotland) Act 2000. I was not involved in committee scrutiny of the Adults with Incapacity (Scotland) Bill, so I am not so conversant with that legislation. However, it seems a bit messy to have to use new legislation for people who are covered by existing legislation.

Paul Gray: I was not involved in the Adults with Incapacity (Scotland) Bill either, so I apologise for that. As the minister explained, we are trying to use the bill to add another building block to the suite of available measures. Those include the provisions of the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and other legislation on protection of vulnerable groups. It should not be impossible for councils to use those provisions because of a barrier that is related to access or urgent intervention.

Shona Robison: I will ask a question on the back of that before I ask my other question. If you discover, when you get to a person through the measures in the bill, that they have capacity such that measures under the 2000 act would not be appropriate, why would you want to override their consent? If you established that they have

capacity, should not that stop their consent being overriden?

Lewis Macdonald: The issue arises when there is good reason to believe that a person is withholding consent under undue pressure from another person. One of the fundamental points that the bill recognises is that it is possible for a person who has capacity and is not subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 to be in a position in which they are not fully free to exercise their rights and to give their consent freely. Undue pressure would have to be demonstrated to the satisfaction of a court before that action could be taken. In the context of the bill and of the protection orders for which it provides, it is important to recognise that we are talking about what is expected to be a small number of cases in which additional powers are required to protect people who are in a difficult position.

Shona Robison: We will come back to the numbers issue shortly. Some bodies, particularly those that represent people who have disabilities and who should in theory benefit from the bill, appear to have real concerns about the bill. Why do you think that is?

Lewis Macdonald: I have read the evidence that you mention and have considered some of the points that have been made. I am keen to ensure that when we come—as I hope we do—to stage 2 and consider the detail of the bill, that some of the specific points that have been raised are fully taken into account.

Clearly, there are different perspectives on the position of adults who are at risk from abuse. I accept that concerns have been raised, in particular in a disability context, that the consequence of acting to protect the most vulnerable should not in some way discriminate or distinguish between different categories of adult. We recognise that and want to address it at stage 2. Nonetheless, the fundamental purpose of the bill is to protect people who are perhaps less able to express their own wishes which, in a sense, goes back to Shona Robison's earlier question. The focus of the bill is particularly on adults who, although they have capacity, are for one reason or another not well positioned to express their views or to ensure that their interests are properly protected. We are concerned about those people rather than about the generality of the population.

Shona Robison: Can we examine that a bit more closely? It brings us on to the scope of the bill. Are you acknowledging that the scope of the bill is too wide in respect of the groups that it covers?

Lewis Macdonald: Not necessarily—but I am acknowledging that there are issues around the definition of adults who may be at risk. I want to come back and address the issue in a way that will ensure that there is no unreasonable distinction within the general population. However, I think that the focus of the bill is not on the general population or the generality of disabled people, older people or people who are ill in one way or another, but on a small group of people who currently fall between the stools of existing legislation.

Shona Robison: You say that, but one of the case studies that you highlight in your letter to the committee focuses on William, who is a frail older person who suffers from alcohol abuse. I could, from my social work days, list dozens of cases in which someone abuses alcohol, becomes vulnerable and is then preyed on by others who use their house as a drinking den. You are mistaken if you are seriously suggesting that there will be only one or two such cases.

The crux of the matter is whether William is prepared to accept help. Your letter suggests that the possible outcome is that a removal order could be put in place to remove William from his own home to enable an assessment to be carried out. If William does not want to be removed from his home but wants to continue to keep bad company and abuse alcohol, and if he has capacity, given that the top of page 2 mentions that

"there is no evidence of serious cognitive impairment",

the thought—and, frankly, the sight—of him being physically carried from his home against his will, possibly in the full glare of the media, is cause for concern to the committee. Despite his bad judgment and self-neglect, are we really saying that the wishes of such a person who has capacity will be overturned and that he could be made the subject of a removal order?

16:00

Lewis Macdonald: Are you saying that William should be left to drink himself to death, or until his friends had spent all his money?

Shona Robison: That is the judgment that needs to be made. If you are saying that people who self-harm and self-neglect will come within the scope of the bill, you are talking about many people—I assure you that that will represent a wide group of people. If that is what you mean, say it and we will know where we stand. The question will then be whether the committee thinks the scope of the bill should be that wide.

Lewis Macdonald: You have identified one particular aspect of the case study, but the case study is typical in the sense that it involves an aggregate of different circumstances that would leave a person vulnerable. In our earlier discussion on how we assess the impact of the

Mental Health (Care and Treatment) (Scotland) Act 2003 on budgets, I accepted that we can make only a best estimate. Similarly on this issue, at this stage I can offer only a best estimate of the scale of the potential requirements, given the experience of those who are already developing practical expertise in the area. That may not be the full picture.

However, to respond to Shona Robison's questions, I believe that, if there are more people in the community who are caught in such circumstances and who are suffering serious harm as a consequence, we should be concerned to address that and to do something about it.

Shona Robison: Of course we should, but the issue is how we address that. Should we take people's rights away and impose services, regardless of whether they want them?

In the case study that was discussed earlier, Thomas's request not to involve the police is to be respected, but his refusal to grant access to the house—whether access is refused by Thomas, his wife or by both is unclear, but let us assume that it is by both—is not to be respected. He is to be allowed to refuse police involvement, but he is not to be allowed to refuse entry to his own home. If Thomas says that the matter is a domestic situation that he and his wife can resolve, a possible outcome is that a banning order will be put in place and access to the house will be obtained. I am worried about the issue of consent. Consent should be established through sensitive dialogue, in order to determine whether the person is under undue pressure. However, if all that dialogue is ignored and the person says, "I don't want you in my home and I don't want your involvement—go away", but the services still go in, an issue of consent arises that we need to address.

Lewis Macdonald: That is an issue, but let me mention a couple of things in response to the line of questioning. First, the assessment order is fundamental to all this. The provision states something to the effect that the assessment order will be in force for seven days, but in most cases the assessment is likely to take a couple of hours rather than a number of days. That is an important point.

Secondly, the protection orders allow for a right of entry, but we do not envisage that a consequence of the bill will be forcible removal of William or whoever from his home. Clearly, if the individual refuses to adhere to the order at the point at which it is served, the bill does not provide for that individual to be, for example, arrested. The point of such orders is not to criminalise adults who are at risk or to arrest them for unwillingness to conform: their point is to protect them.

Shona Robison: That is not what the bill says—

The Convener: I ask Shona Robison to hold on, as I know that Duncan McNeil and Euan Robson have supplementary questions. Obviously, this discussion will run for a bit.

Mr McNeil: The scenarios are all very interesting. I could turn the second scenario into an episode of "Taggart", in which William is eventually murdered by his alcoholic friends and whatever—

The Convener: Duncan, will you stick to the question?

Mr McNeil: No, Shona Robison had 10 minutes for her point.

We should not go from point A to point Z in one jump. In the scenario that we are talking about, I could see the person falling into a state in which, although he might have some capacity, his capacity becomes more impaired and people are living off his benefits. Where is the intervention? How do we take away the excuses from the services that should intervene to ensure that he has a care package and support for his alcohol dependency instead of going in only to drag him off in the middle of the night? There is certainly a gap in services. The elderly are particularly vulnerable to the people on whom they increasingly become dependent. That is the principle of the bill and we are getting into stage 2 arguments. Either the committee accepts that there is a gap that needs to be addressed—

The Convener: Duncan, that is what this discussion is about.

Mr McNeil: With all due respect, convener, it is not at this point.

Euan Robson: Is not section 1(b) part of the way in which the bill copes with the point that Shona Robison made? It states that the intervention must be

"the least restrictive to the adult's freedom."

As I read it, that qualifies the course of action that Shona Robison rightly addresses. If it means something different, what does it mean?

Lewis Macdonald: Section 1(b) says that the least restrictive option should be taken. That reflects Duncan McNeil's point that we are talking about a process—a set of available steps. Shona Robison is right to say that there are hundreds—sadly, it is thousands—of people throughout Scotland who abuse alcohol and are damaging themselves. The bill does not say that we should move from where we are to the final stage in the process for all those people; instead, it sets out a series of steps and interventions of which the most extreme—the last step in the process, if it is required—is an order that is granted without

consent because there is deemed to be undue pressure. My suspicion is that, in reality, in the vast majority of circumstances, carrying out an assessment and taking the first step will prompt the kind of change and service delivery that are required. Failing that, granting a mandatory order will be enough to persuade most of those who have not yet been persuaded that there is a need to change the service provision for the individual concerned.

A series of measures is laid out in the bill. At one end of the spectrum are measures to be taken in cases in which consent has not been given but the court still determines that the person's best interest is served by intervention. However, I suspect that the bill's main impact will be through much less restrictive measures that make a difference and protect the individual in question from abuse.

Janis Hughes: I have some questions on definitions in the bill. At different points, it defines "adults at risk" and "abuse". A number of witnesses who have appeared before us have concerns about the term "abuse", particularly because it is a pejorative term and perhaps not appropriate for the bill but also because it does not cover some circumstances that the bill might cover, such as neglect, which is a form of unintentional abuse. We have had suggestions for alternative terms, such as "adults at risk of serious harm". I ask the minister for his view on those definitions and whether he is willing to consider the concerns that have been raised with us.

Lewis Macdonald: I do not want to prejudge any stage 2 amendments—that would not be appropriate—but I take on board the points that have been raised on definitions and, for example, the distinction between abuse and harm. It is clear that under the bill we want to offer protection to, for example, an elderly person who lives with a partner in circumstances in which, although there is no intention on anyone's part that the individual should come to harm, because of a combination of circumstances, harm results. I accept that it would be useful to reconsider some of the definitions to ensure that we offer protection to all those whom we want to protect in a way that people recognise as achieving that objective and not inadvertently achieving some other outcome.

Janis Hughes: Section 3 defines adults at risk as people who are

"affected by disability, mental disorder, illness, infirmity or ageing."

Concerns have been raised about the broadness of some of those terms, such as "illness" and "ageing". If I have the flu, I am ill—and I am obviously aging. Some people feel that the definitions are too broad. How could they be made clearer?

Lewis Macdonald: Everyone is aging—that is technically correct, as you say. We acknowledge that we must think carefully about the definitions. On the one hand, I do not want to exclude adults who might be at risk, but, on the other hand, we would not expect local authorities to investigate situations and circumstances that affect the whole adult population.

If the committee is content to proceed at this stage, I would be happy to come back at stage 2 with suggestions on how we might achieve our objective, which I think Janis Hughes supports, given her line of questioning. We want to provide support in ways that are non-discriminatory and effective.

The Convener: Helen, you normally ask trigger questions, but I think that the minister has answered some of the questions that you would have asked.

Helen Eadie: When I re-read the *Official Report* and various other documents that we have received via the internet and from elsewhere, I was impressed to see that more than two thirds of people warmly welcome the bill. It was interesting to be reminded of that, because sometimes when we sit through evidence-taking sessions we get confused by all the messages that we get. When you sit down with a cold towel over your head and really get down to reading the evidence, you understand it.

I speak from experience, as an elderly constituent of mine had Diogenes syndrome. All the people around her judged her to have full capacity, but she was living in the most horrific circumstances in the whole of Scotland—the case was televised and a great deal of publicity surrounded it.

Minister, how do you envisage investigations taking place? Do you envisage them happening in an emergency situation or over a longer period, with all agencies having an earlier warning system?

Lewis Macdonald: Broadly speaking, we envisage authorities being given a statutory duty to act where they have reason to believe that a person is suffering or is at serious risk of harm. The authority would have to follow the steps, starting with the action that you would expect them to take in any case. An additional range of actions will be available to them, should they prove necessary.

Helen Eadie: The minister has answered the rest of my questions.

The Convener: I want to raise more specific issues. There is no mention of independent

advocacy in the bill, which was incorporated specifically in the Mental Health (Care and Treatment) (Scotland) Act 2003. Is that a deliberate and considered omission, or was the matter simply overlooked and could be reconsidered?

Lewis Macdonald: Given that stark choice, I would tend towards the latter. We would certainly not want to rule out independent advocacy.

The Convener: The point was raised frequently. Independent advocacy could be considered to be an essential part of the bill, given some of the concerns.

Lewis Macdonald: Yes. It is provided for in the 2003 act. Given Kate Maclean's questions about ensuring that we do not unduly override other provisions, we would want to be consistent if we can be. I am happy to come back to the committee on that at stage 2.

The Convener: The other issue that I wanted to raise is appealability of the orders. Concern has been raised about the fact that one of the orders is appealable, but the others are not. It has been suggested that the orders would be very open to challenge, given their draconian nature. I wonder about the thinking behind the decision to leave an appeals process out of the bill although most people think that one should have been included.

16:15

Lewis Macdonald: I will respond to that and my officials will keep me right. The bill mentions a number of different orders. The removal order and the assessment order both have a limited life and there is no appeals process for them. Those orders have a short duration and are intended to provide an urgent response to an urgent situation in the circumstances that Helen Eadie asked about. Banning orders have a longer duration and there is a right of appeal in relation to them. To follow the analogy that was made earlier, a temporary banning order will be the interim version, and there will be a right of appeal with the approval of the sheriff principal. However, for a longer-term banning order, there will be a right of appeal without the matter first being referred to the sheriff principal.

Measures that have a very short term and that are intended to provide a quick response to an urgent situation cannot be appealed. I hope that the proposal for an assessment order will receive broad support, as it signals a recognition that there is an issue and that an assessment needs to be made. The order will allow that assessment to be carried out within seven days of its being granted, which I think is proportionate. Likewise, removal orders are about removing a person essentially for their own safety, and removal will have to be carried out within 72 hours of the order being made. Again, it is an immediate response to an immediate circumstance. The banning order has a longer duration; therefore, it is appropriate for its provision to include a right of appeal.

The Convener: The issue of the lack of an appeals process having been raised, I wonder whether you will go away and have a think about it. The fact that the issue has been raised suggests that the lack of an appeals process would be challenged further down the line, and none of us around the table could say with certainty what the result of such a challenge would be.

Lewis Macdonald: Indeed. All such matters require the best judgment to be made on the basis of the legal advice and evidence that are available. The judgment of those who advise ministers in such matters is that the current provisions achieve the right balance. Nevertheless, I would be happy to consider the matter further at stage 2 and to have further discussions with the committee about it.

The Convener: Some of the witnesses also raised a concern about how effective the banning orders would be without having a power of detention or interdict attached to them. There would be little to prevent someone who was the subject of a banning order from simply returning, as the order would rely entirely on the other person in the house alerting the police to the fact that the person had returned. The concern is that it will be difficult to monitor the effectiveness of the orders in practice.

Lewis Macdonald: Such concerns can also arise in the context of other, similar interdicts. Paul Gray might like to respond to that.

Paul Gray: Section 25 states:

"A constable may arrest without warrant the subject of any banning order, or temporary banning order",

and so on. A banning order has the power of an interdict.

The Convener: But the constable would have to be advised that the banning order had been breached. If people—including the other person in the household—were not happy with the circumstances in which the banning order had been made, what capacity would there be to do anything about the breach?

Lewis Macdonald: The situation is parallel to the one that arises with interdicts. I suspect that, like me, committee members will have constituents who have been protected by an interdict but who have not reported a breach of that interdict by the individual concerned. That is a difficult circumstance for which we make no special provision in the bill.

The Convener: Except, as Kate Maclean rightly pointed out, the difference is that in most circumstances the other person will have initiated the interdict whereas in the situation that you describe, it might not be the other person who initiates the demand for the banning order. That creates a qualitative difference in the relationship.

Lewis Macdonald: It is different, but I am not sure whether it makes a difference to the police officer's ability either to know whether the interdict has been broken or to act upon its breach.

The Convener: If the individual who made the complaint that gives rise to the interdict is no longer acting in the way that gave rise to the complaint in the first place, that creates a different scenario. That would not necessarily be the case with a banning order. The question that was raised was how effective the banning order could be if it was initiated without the consent of the person protected.

Lewis Macdonald: I understand the point. In circumstances in which the person protected had not given their consent, which I expect would be unusual, the banning order would have been sought by another party—the local authority in most cases. The local authority would then have an interest in ensuring that the banning order was adhered to.

I hope that part of the response to the individual's circumstances being drawn to the authority's attention by the assessment would be to put in place services to support that individual. Therefore, the authority would be aware if the banning order had been breached. I acknowledge the importance of your point, but it should be seen in the wider context of the response to the individual's condition.

Euan Robson: What assessment has the Executive made of the possible requirement for additional resources, particularly for accommodation support services and respite care? Can the current arrangements provide for that?

Lewis Macdonald: We recognise that resources might be required in a couple of areas. One is the provision of adult protection mechanisms, including committees that we expect each local authority to put in place, and the other is provision of care managers, who would be responsible for the delivery of services to the individuals in question. Members have seen the figures, which we have assessed at about £5 million for each area. Given the recent work that the adult protection unit in the Borders has done, it provided us with the best basis on which to estimate the potential cost. That is the ballpark that we are in.

We do not expect that a person being removed under a removal order—I stress that such a circumstance would be unusual—would be removed for a significant length of time. Members will be aware of the limits on the length of time in the legislation. Therefore, we do not expect that to have significant additional resource implications for the bill.

Euan Robson: But you might consider additional resources for those circumstances.

Lewis Macdonald: We will want to be assured that they have been taken into account.

The Convener: Undue pressure has already been discussed. Does Jean Turner wish to raise other aspects of the subject?

Dr Turner: Does the minister wish to add anything? Does the convener want me to ask about the human rights aspect?

The Convener: There has already been some discussion about that. Perhaps the minister will address a point that was raised by Enable Scotland, which said that if someone were to make a clear decision that a third party might consider to be irrational, would such a decision automatically be deemed to have been arrived at because of undue pressure?

Lewis Macdonald: No. Undue pressure must be shown and the bill makes it clear how that condition must be met. There must be two aspects. First, the abuse or neglect must have been inflicted by a person in whom the victim of the abuse or neglect has trust and confidence. Secondly, evidence will be needed that the individual would reach a different decision if they did not have that trust and confidence in the person who may have inflicted abuse or neglect. Section 32(4) sets out a particular requirement.

The Convener: Were you surprised by the number of representative organisations that expressed considerable concern?

Lewis Macdonald: Helen Eadie mentioned that she had read the responses and found that the weight of responses supported the bill but that a significant number expressed concerns. I was a little surprised that people's concerns appeared to take precedence over the bill's wider principles. Perhaps that is simply the nature of evidence giving—people highlight concerns rather than focus on what they welcome.

On the basis of the correspondence that I have seen, particularly in recent days, following the evidence-taking sessions, I suspect that what the bill seeks to do has strong support, but clearly that support is not universal.

The Convener: I appreciate the position. The perception was that several organisations had

been strongly encouraged by people—including you—to ensure that all committee members were inundated with letters. Nevertheless, most of those letters came from groups that represent the elderly or the aged and not necessarily from people whom the likes of Enable or Capability Scotland represent. A clear distinction still appears to exist between organisations that represent the elderly, which are very supportive of the bill, and other organisations, which are at best ambivalent and at worst quite resistant. The difficulty is that the bill is not just about the elderly; it is about the people supported by all those organisations.

Lewis Macdonald: Indeed. We want to support the most vulnerable people whichever category they fall into. In recent days, several organisations have contacted me or my officials to express their concerns and have been encouraged to do whatever they want to do on their own behalf—it is not for us to determine what view the committee or any other organisation should take on the bill. When people welcome the bill, I welcome that.

As you say, organisations that have welcomed the bill include several that are concerned with older people. They also include a range of advocacy services that represent a range of people—several such organisations have contacted me. Alzheimer Scotland—Action on Dementia, which covers a category of people who are vulnerable through age and for other reasons, the Association of Directors of Social Work, the Convention of Scottish Local Authorities and several other organisations have also contacted me and—I suspect—committee members to express their views about the importance of the bill.

Dr Turner: The gap in the legislation needs to be filled. I thank you for the information that you have provided, which it would have been nice to have at the beginning of the process. From my experience, I know of the gap and of the need to enter and assess people. I would change my mind about the bill if you truly took on board all the fears that the committee has discussed and has heard from witnesses. How the bill will work in practice is difficult to accept.

Lewis Macdonald: You and the convener are right to highlight concerns that have been expressed, but it is broadly recognised that some adults who are at risk are not fully protected by existing legislation and practice and we need to ensure that authorities have powers to act and are willing and able to use those powers. The bill is intended to enable and encourage them to do that and to create new statutory responsibilities. The matter is serious, which is why, as I have said, we are collectively happy to consider concerns that have been expressed, particularly by some of the organisations that have been mentioned, to ensure that we have a bill that works.

16:30

Shona Robison: I seek clarification on one issue, which could be given either today or in writing. The table on the page after page 4 in your letter compares the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the bill. It states that, under the 2000 act, community care team staff can act; that, under the 2003 act, mental health officers or doctors can act; but that, under the bill, any council officer will be able to act. Is that definition not a bit wide for these duties? Can that matter be examined, please?

Lewis Macdonald: That entry in the table simply reflects what the bill states, which is that an officer acting on behalf of the council shall have certain powers.

Shona Robison: That needs to be tied down somewhat.

Lewis Macdonald: Again, I am happy to consider that further at stage 2. The aim is clearly to cover those who have responsibility for protecting individuals.

Euan Robson: Some of the organisations that have raised worries about the bill with the committee were on the steering group. Did they raise those concerns during the steering group meetings? Will you consider reconvening the group?

I also have a specific point about the desirability of transitional arrangements for when a person's ordinary residence is being decided. Will you introduce specific transitional arrangements to assist individuals for whom a delay occurs in the determination of their ordinary residence?

Lewis Macdonald: To answer your first question, several of the concerns that have been raised in the committee were raised and discussed in full in the steering group. As a consequence of those issues, there were one or two dissenting voices. In engaging further in the process, we want, in the way in which I have described, to address some of the concerns that were raised at that stage and in the committee.

Forgive me, but what was your second point?

Euan Robson: It was about transitional arrangements for people for whom a determination is being made on ordinary residence. If a difficulty arises, perhaps because two local authorities are trying to come to a decision, that will lead to delay. Is it possible to introduce transitional arrangements to protect the individual concerned?

The question arises from a specific case that was raised with the committee.

Lewis Macdonald: That is an interesting question. Part 4 of the bill will allow us to make transitional arrangements by order.

Euan Robson: I am sure that the clerks can provide details of that issue, which perhaps could be considered at stage 2.

The Convener: Helen Eadie has what must be the final final point.

Helen Eadie: It is. Of the 33 responses that we received, 28 supported the bill. The submission from Community Care Providers Scotland raised a point that also arose during our earlier deliberations on the budget. The organisation is disappointed that voluntary sector providers are not to be represented on adult protection committees. I hope that that suggestion will be considered at stage 2, as the issue is important. The voluntary sector provides a range of support throughout Scotland, so I would like that suggestion to be taken up.

Lewis Macdonald: I agree that that is an important point. I also agree with Helen Eadie on the important role of the voluntary sector. I am happy to return to the issue at stage 2.

The Convener: I thank the minister and his officials for their evidence. I apologise for the length of time that the minister has had to be before us, in two capacities. If it is any consolation, I point out that he is finished, but we are not.

Lewis Macdonald: That is some consolation.

Subordinate Legislation

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment (No 3) Regulations 2006 (SSI 2006/440)

Food (Emergency Control) (Scotland) Revocation Regulations 2006 (SSI 2006/459)

The Convener: Agenda item 5 is consideration of subordinate legislation under the negative procedure. The Subordinate Legislation Committee raised a question about the timetable for Scottish statutory instrument 2006/440, but raised no other issues on either set of regulations. No comments from members have been received and no motions to annul have been lodged. Therefore, do members agree that the committee should make no recommendation on the regulations?

Members *indicated agreement*.

The Convener: That ends the public part of our business. I ask all those who are not required for or involved in the private session to leave the room.

16:35

Meeting continued in private until 17:39.

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